

**Rural Health Care (RHC) Universal Service
Eligibility and Registration Form**

Read instructions thoroughly before completing this form. Failure to comply may cause delayed or denied funding.

Block 1: General Information

1 Date Submitted: 03/06/2014	
2 Applying to:	<input checked="" type="radio"/> Determine eligibility of an HCP site <input type="radio"/> Determine eligibility of Consortium <input type="radio"/> Register an off-site data center
	<input type="radio"/> Register an ineligible site <input type="radio"/> Register an off-site administrative office
2a If applying as an off-site data center, list all sites (eligible and ineligible) that will use the services of this data center.	
2b If applying as an off-site administrative office, list all sites (eligible and ineligible) that will use the services of this administrative office.	

Block 2: Site Information – Physical Site

Enter the actual physical location of the site.			
3 HCP Number 36031		4 Site Name California Institution for Men	
5 Name of Legal Entity California Institution for Men			
6 Enter FCC Registration Number (FCC RN) for Line 5 legal entity: 0020046264			
6a If the Line 5 legal entity does not have an FCC RN and only plans to participate as a consortium member, applicant may enter FCC RN for the Consortium (see instructions for more detail):			
7 Site Contact Name Peggy A. Baker			
8 Address Line 1 14901 Central Avenue			
9 Address Line 2		10 County San Bernardino	
11 Geo Location (if no street address)			
12 City Chino		13 State CA	14 Zip Code 91710
15 Phone (760) 397-3259 Ext.		16 Email Peggy.A.Baker@cdcr.ca.gov	

Block 3: Consortium Information

17 HCP Number	
18 Name of Consortium	
19 Is the Consortium a legal entity? <input type="radio"/> Yes <input type="radio"/> No If yes, Consortium FCC RN:	
20 Consortium has a written agreement allocating legal and financial responsibility. <input type="radio"/> Yes <input type="radio"/> No	
If yes, submit the agreement to USAC. If no, see instructions regarding the default entity that bears legal and financial responsibility for the consortium's activities in connection with the Healthcare Connect Fund.	
21 Consortium Leader Type:	
<input type="radio"/> The Consortium <input type="radio"/> An eligible HCP participating in the Consortium HCP Number: _____	
<input type="radio"/> Ineligible State organization <input type="radio"/> Ineligible public sector (government) entity <input type="radio"/> Ineligible non-profit entity	
A state organization, public sector entity, or non-profit entity may obtain an exemption to allow the organization to perform vendor functions and provide application assistance. Submit any such request for exemption.	
22 Consortium Leader Contact Information	
23 Name of Consortium Leader	
Consortium applicants are required to have a Letter of Agency from each eligible HCP that authorizes the Consortium to file forms on the HCP's behalf. Submit a Letter of Agency for each eligible HCP.	
24 List participating sites by HCP Number (eligible/ineligible)	

Block 4: Contact Information

25 Primary Account Holder/Project Coordinator Name Sherri Bridges	
26 Employer CDCR California Correctional Health Care Services	
27 Address Line 1 8260 Longleaf Drive <input type="radio"/> Same as Physical Location	
28 Address Line 2 Bldg. C3-616	
29 City Elk Grove	
30 State CA	
31 Zip Code 95758	
32 Phone # (916) 691-3531 Ext.	
33 Email Sherri.Bridges@cdcr.ca.gov	

34 Secondary Account Holder (Application Contact/Assistant Project Coordinator) Rosie Williams		
35 Employer CDCR California Correctional Health Care Services		
36 Address Line 1 8260 Longleaf Drive		<input checked="" type="checkbox"/> Same as Primary Account Holder Address
37 Address Line 2 Bldg. C3-616		
38 City Elk Grove	39 State	40 Zip Code 95758
41 Phone # (916) 691-3100 Ext.	42 Email Rosie.Williams@cdcr.ca.gov	
Block 5: Eligibility Category		
43 Select the category that describes the HCP site (If seeking an eligibility determination for a Consortium, "Consortium of the above" will be automatically selected)		
<input type="radio"/> A. Community health center or health center providing health care to migrants		
<input type="radio"/> B. Community mental health center		
<input type="radio"/> C. Local health department/agency		
<input type="radio"/> D. Non-profit hospital		
<input type="radio"/> E. Part-time eligible entity located in an ineligible facility		
<input type="radio"/> F. Post-secondary educational Institution offering health care instruction, teaching hospital, or medical school		
<input checked="" type="radio"/> G1. Rural health clinic		
G2. Is this a mobile rural health care provider? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
<input type="radio"/> H. Dedicated ER of rural, for-profit hospital		
<input type="radio"/> I. Consortium of the above		
44 Provide a brief explanation of why this site qualifies as the organization type selected above: CDCR CCHCS owns and operates 35 health clinics state-wide. 19 of those sites are rural and have participated in the Telecommunications Program since Sept. 2010. This is an urban HCP within the consortium that meets the 51% rural majority req.		
Block 6: Additional Information		
45 Non-Profit Tax ID (EIN): 870746811		
46 National Provider Identifier: 1396169405	47a Organization Taxonomy Code: 261QP2400X	
Explanation if necessary (see instructions)	47b Site Taxonomy Code: 261QP2400X	
	Explanation if necessary (see instructions)	
48 If a Non-Profit Hospital, is this a Critical Access Hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No		
49 If a Non-Profit Hospital, how many licensed patient beds are at the site? _____		
50 Is the site location: <input type="checkbox"/> On Tribal lands <input type="checkbox"/> Otherwise affiliated with a Tribe		
<input type="checkbox"/> Operated by the Indian Health Service <input checked="" type="checkbox"/> N/A		
51 [Reserved]	52 [Reserved]	
Block 7: Certifications and Signatures		
53 <input checked="" type="checkbox"/> I certify that I am authorized to submit this request on behalf of the site or consortium.		
54 <input checked="" type="checkbox"/> I declare under penalty of perjury that I have examined this form and attachments and to the best of my knowledge, information, and belief, all information contained in this form and in any attachments is true and correct.		
55 <input checked="" type="checkbox"/> If applying as an individual health care provider site, I certify that the health care provider is a non-profit or public entity and that the site is located in a FCC designated rural area, or is grandfathered rural pursuant to 47 C.F.R. Sec. 54.600(b)(2).		
56 <input type="checkbox"/> If applying as a consortium, I certify that the eligible health care providers participating in the consortium are non-profit or public entities.		
57 <input checked="" type="checkbox"/> I understand that all documentation associated with this form must be retained for a period of at least five years pursuant to 47 C.F.R. § 54.648, or as otherwise prescribed by the Commission's rules.		
58 <input type="checkbox"/> If applying as a consortium, I understand I must obtain letters of agency from each consortium member that grants me the authority to complete, sign, and submit all forms for the funding year(s) for which support is sought.		

59 Signature	60 Date 03/06/2014
61 Printed Name of Authorized Person Tammy Sullivan-King	
62 Title/Position of Authorized Person Subject Matter Expert	
63 Phone (916) 691-6575 Ext.	64 Email Tammy.Sullivan-King@cdcr.ca.gov
65 Employer Task Consulting, Inc.	66 Employer's FCC RN 0019191253

Persons willfully making false statements on this form can be punished by fine or forfeiture under the Communications Act, 47 U.S.C. Secs. 502, 503(b), or fine or imprisonment under Title 18 of the United States Code, 18 U.S.C. Sec. 1001.

FCC NOTICE FOR INDIVIDUALS REQUIRED BY THE PRIVACY ACT AND THE PAPERWORK REDUCTION ACT

Part 3 of the Commission's Rules authorize the FCC to request the information on this form. The purpose of the information is to determine your eligibility for certification as a health care provider. The information will be used by the Universal Service Administrative Company and/or the staff of the Federal Communications Commission, to evaluate this form, to provide information for enforcement and rulemaking proceedings and to maintain a current inventory of applicants, health care providers, billed entities, and service providers. No authorization can be granted unless all information requested is provided. Failure to provide all requested information will delay the processing of the application or result in the application being returned without action. Information requested by this form will be available for public inspection. Your response is required to obtain the requested authorization.

The public reporting for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the required data, and completing and reviewing the collection of information. If you have any comments on this burden estimate, or how we can improve the collection and reduce the burden it causes you, please write to the Federal Communications Commission, AMD-PER, Paperwork Reduction Act Project (3060-0804), Washington, DC 20554. We will also accept your comments regarding the Paperwork Reduction Act aspects of this collection via the Internet if you send them to pra@fcc.gov. PLEASE DO NOT SEND YOUR RESPONSE TO THIS ADDRESS.

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THE FOREGOING NOTICE IS REQUIRED BY THE PRIVACY ACT OF 1974, PUBLIC LAW 93-579, DECEMBER 31, 1974, 5 U.S.C. 552a(e)(3) AND THE PAPERWORK REDUCTION ACT OF 1995, PUBLIC LAW 104-13, OCTOBER 1, 1995, 44 U.S.C. SECTION 3507.

Third Party Authorization Upload:
Third Party Authorization Effective Start Date:
Third Party Authorization Effective End Date:

Block 4: Contact Information

34 Secondary Account Holder (Application Contact/Assistant Project Coordinator)		
35 Employer		
36 Address Line 1		<input type="radio"/> Same as Primary Account Holder Address
37 Address Line 2		
38 City	39 State	40 Zip Code
41 Phone #	Ext.	42 Email

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Block 2: Site Information – Physical Site

Enter the actual physical location of the site.			
3 HCP Number 36039		4 Site Name California Institution for Women	
5 Name of Legal Entity California Institution for Women			
6 Enter FCC Registration Number (FCC RN) for Line 5 legal entity: 0020046264			
6a If the Line 5 legal entity does not have an FCC RN and only plans to participate as a consortium member, applicant may enter FCC RN for the Consortium (see instructions for more detail):			
7 Site Contact Name Peggy A. Baker			
8 Address Line 1 16756 Chino-Corona Road			
9 Address Line 2		10 County Riverside	
11 Geo Location (if no street address)			
12 City Corona		13 State CA	14 Zip Code 92880
15 Phone (760) 397-3259 Ext.		16 Email Peggy.A.Baker@cdcr.ca.gov	

Block 3: Consortium Information

17 HCP Number	
18 Name of Consortium	
19 Is the Consortium a legal entity? <input type="radio"/> Yes <input type="radio"/> No If yes, Consortium FCC RN:	
20 Consortium has a written agreement allocating legal and financial responsibility. <input type="radio"/> Yes <input type="radio"/> No	
If yes, submit the agreement to USAC. If no, see instructions regarding the default entity that bears legal and financial responsibility for the consortium's activities in connection with the Healthcare Connect Fund.	
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24 List participating sites by HCP Number (eligible/ineligible)	

Block 4: Contact Information

25 Primary Account Holder/Project Coordinator Name Sherri Bridges	
26 Employer CDCR California Correctional Health Care Services	
27 Address Line 1 8260 Longleaf Drive <input type="radio"/> Same as Physical Location	
28 Address Line 2 Bldg. C3-616	
29 City Elk Grove	
30 State CA	
31 Zip Code 95758	
32 Phone # (916) 691-3531 Ext.	
33 Email Sherri.Bridges@cdcr.ca.gov	

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Block 5: Eligibility Category		
43 Select the category that describes the HCP site (If seeking an eligibility determination for a Consortium, "Consortium of the above" will be automatically selected)		
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<input type="radio"/> B. Community mental health center		
<input type="radio"/> C. Local health department/agency		
<input type="radio"/> D. Non-profit hospital		
<input type="radio"/> E. Part-time eligible entity located in an ineligible facility		
<input type="radio"/> F. Post-secondary educational Institution offering health care instruction, teaching hospital, or medical school		
<input checked="" type="radio"/> G1. Rural health clinic		
G2. Is this a mobile rural health care provider? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
<input type="radio"/> H. Dedicated ER of rural, for-profit hospital		
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44 Provide a brief explanation of why this site qualifies as the organization type selected above: CDCR CCHCS owns and operates 35 health clinics state-wide. 19 of those sites are rural and have participated in the Telecommunications Program since Sept. 2010. This is an urban HCP within the consortium that meets the 51% rural majority req.		
Block 6: Additional Information		
45 Non-Profit Tax ID (EIN): 870746811		
46 National Provider Identifier: 1396169405	47a Organization Taxonomy Code: 261QP2400X	
Explanation if necessary (see instructions)	47b Site Taxonomy Code: 261QP2400X	
	Explanation if necessary (see instructions)	
48 If a Non-Profit Hospital, is this a Critical Access Hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No		
49 If a Non-Profit Hospital, how many licensed patient beds are at the site? _____		
50 Is the site location: <input type="checkbox"/> On Tribal lands <input type="checkbox"/> Otherwise affiliated with a Tribe		
<input type="checkbox"/> Operated by the Indian Health Service <input checked="" type="checkbox"/> N/A		
51 [Reserved]	52 [Reserved]	
Block 7: Certifications and Signatures		
53 <input checked="" type="checkbox"/> I certify that I am authorized to submit this request on behalf of the site or consortium.		
54 <input checked="" type="checkbox"/> I declare under penalty of perjury that I have examined this form and attachments and to the best of my knowledge, information, and belief, all information contained in this form and in any attachments is true and correct.		
55 <input checked="" type="checkbox"/> If applying as an individual health care provider site, I certify that the health care provider is a non-profit or public entity and that the site is located in a FCC designated rural area, or is grandfathered rural pursuant to 47 C.F.R. Sec. 54.600(b)(2).		
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38 City	39 State	40 Zip Code
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Block 2: Site Information – Physical Site

Enter the actual physical location of the site.			
3 HCP Number 36043		4 Site Name California Rehabilitation Center	
5 Name of Legal Entity California Rehabilitation Center			
6 Enter FCC Registration Number (FCC RN) for Line 5 legal entity: 0020046264			
6a If the Line 5 legal entity does not have an FCC RN and only plans to participate as a consortium member, applicant may enter FCC RN for the Consortium (see instructions for more detail):			
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8 Address Line 1 5th Street and Western			
9 Address Line 2		10 County Riverside	
11 Geo Location (if no street address)			
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62 Title/Position of Authorized Person Subject Matter Expert	
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35 Employer		
36 Address Line 1		<input type="radio"/> Same as Primary Account Holder Address
37 Address Line 2		
38 City	39 State	40 Zip Code
41 Phone #	Ext.	42 Email

**Rural Health Care (RHC) Universal Service
Eligibility and Registration Form**

Read instructions thoroughly before completing this form. Failure to comply may cause delayed or denied funding.

Block 1: General Information

1 Date Submitted: 03/06/2014	
2 Applying to:	<input checked="" type="radio"/> Determine eligibility of an HCP site <input type="radio"/> Determine eligibility of Consortium <input type="radio"/> Register an off-site data center <input type="radio"/> Register an ineligible site <input type="radio"/> Register an off-site administrative office
2a If applying as an off-site data center, list all sites (eligible and ineligible) that will use the services of this data center.	
2b If applying as an off-site administrative office, list all sites (eligible and ineligible) that will use the services of this administrative office.	

Block 2: Site Information – Physical Site

Enter the actual physical location of the site.			
3 HCP Number 36069		4 Site Name R.J. Donovan State Prison	
5 Name of Legal Entity R.J. Donovan State Prison			
6 Enter FCC Registration Number (FCC RN) for Line 5 legal entity: 0020046264			
6a If the Line 5 legal entity does not have an FCC RN and only plans to participate as a consortium member, applicant may enter FCC RN for the Consortium (see instructions for more detail):			
7 Site Contact Name Peggy A. Baker			
8 Address Line 1 480 Alta Road			
9 Address Line 2		10 County San Diego	
11 Geo Location (if no street address)			
12 City San Diego		13 State CA	14 Zip Code 92179
15 Phone (760) 397-3259 Ext.		16 Email Peggy.A.Baker@cdcr.ca.gov	

Block 3: Consortium Information

17 HCP Number	
18 Name of Consortium	
19 Is the Consortium a legal entity? <input type="radio"/> Yes <input type="radio"/> No If yes, Consortium FCC RN:	
20 Consortium has a written agreement allocating legal and financial responsibility. <input type="radio"/> Yes <input type="radio"/> No	
If yes, submit the agreement to USAC. If no, see instructions regarding the default entity that bears legal and financial responsibility for the consortium's activities in connection with the Healthcare Connect Fund.	
21 Consortium Leader Type:	
<input type="radio"/> The Consortium <input type="radio"/> An eligible HCP participating in the Consortium <input type="radio"/> Ineligible State organization <input type="radio"/> Ineligible public sector (government) entity <input type="radio"/> Ineligible non-profit entity	
A state organization, public sector entity, or non-profit entity may obtain an exemption to allow the organization to perform vendor functions and provide application assistance. Submit any such request for exemption.	
22 Consortium Leader Contact Information	
23 Name of Consortium Leader	
Consortium applicants are required to have a Letter of Agency from each eligible HCP that authorizes the Consortium to file forms on the HCP's behalf. Submit a Letter of Agency for each eligible HCP.	
24 List participating sites by HCP Number (eligible/ineligible)	

Block 4: Contact Information

25 Primary Account Holder/Project Coordinator Name Sherri Bridges	
26 Employer CDCR California Correctional Health Care Services	
27 Address Line 1 8260 Longleaf Drive <input type="radio"/> Same as Physical Location	
28 Address Line 2 Bldg. C3-616	
29 City Elk Grove	
30 State CA	
31 Zip Code 95758	
32 Phone # (916) 691-3531 Ext.	
33 Email Sherri.Bridges@cdcr.ca.gov	

34 Secondary Account Holder (Application Contact/Assistant Project Coordinator)		
35 Employer CDCR California Correctional Health Care Services		
36 Address Line 1 8260 Longleaf Drive		<input checked="" type="checkbox"/> Same as Primary Account Holder Address
37 Address Line 2 Bldg. C3-616		
38 City Elk Grove	39 State	40 Zip Code 95758
41 Phone # (916) 691-3100 Ext.	42 Email Rosie.Williams@cdcr.ca.gov	
Block 5: Eligibility Category		
43 Select the category that describes the HCP site (If seeking an eligibility determination for a Consortium, "Consortium of the above" will be automatically selected)		
<input type="radio"/> A. Community health center or health center providing health care to migrants <input type="radio"/> B. Community mental health center <input type="radio"/> C. Local health department/agency <input type="radio"/> D. Non-profit hospital <input type="radio"/> E. Part-time eligible entity located in an ineligible facility <input type="radio"/> F. Post-secondary educational Institution offering health care instruction, teaching hospital, or medical school <input checked="" type="radio"/> G1. Rural health clinic G2. Is this a mobile rural health care provider? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="radio"/> H. Dedicated ER of rural, for-profit hospital <input type="radio"/> I. Consortium of the above		
44 Provide a brief explanation of why this site qualifies as the organization type selected above: CDCR CCHCS owns and operates 35 health clinics state-wide. 19 of those sites are rural and have participated in the Telecommunications Program since Sept. 2010. This is an urban HCP within the consortium that meets the 51% rural majority req.		
Block 6: Additional Information		
45 Non-Profit Tax ID (EIN): 870746811		
46 National Provider Identifier: 1396169405	47a Organization Taxonomy Code: 261QP2400X	
Explanation if necessary (see instructions)	47b Site Taxonomy Code: 261QP2400X	
	Explanation if necessary (see instructions)	
48 If a Non-Profit Hospital, is this a Critical Access Hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No		
49 If a Non-Profit Hospital, how many licensed patient beds are at the site? _____		
50 Is the site location: <input type="checkbox"/> On Tribal lands <input type="checkbox"/> Otherwise affiliated with a Tribe <input type="checkbox"/> Operated by the Indian Health Service <input checked="" type="checkbox"/> N/A		
51 [Reserved]	52 [Reserved]	
Block 7: Certifications and Signatures		
53 <input checked="" type="checkbox"/> I certify that I am authorized to submit this request on behalf of the site or consortium.		
54 <input checked="" type="checkbox"/> I declare under penalty of perjury that I have examined this form and attachments and to the best of my knowledge, information, and belief, all information contained in this form and in any attachments is true and correct.		
55 <input checked="" type="checkbox"/> If applying as an individual health care provider site, I certify that the health care provider is a non-profit or public entity and that the site is located in a FCC designated rural area, or is grandfathered rural pursuant to 47 C.F.R. Sec. 54.600(b)(2).		
56 <input type="checkbox"/> If applying as a consortium, I certify that the eligible health care providers participating in the consortium are non-profit or public entities.		
57 <input checked="" type="checkbox"/> I understand that all documentation associated with this form must be retained for a period of at least five years pursuant to 47 C.F.R. § 54.648, or as otherwise prescribed by the Commission's rules.		
58 <input type="checkbox"/> If applying as a consortium, I understand I must obtain letters of agency from each consortium member that grants me the authority to complete, sign, and submit all forms for the funding year(s) for which support is sought.		

59 Signature	60 Date 03/06/2014
61 Printed Name of Authorized Person Tammy Sullivan-King	
62 Title/Position of Authorized Person Subject Matter Expert	
63 Phone (916) 691-6575 Ext.	64 Email Tammy.Sullivan-King@cdcr.ca.gov
65 Employer Task Consulting, Inc.	66 Employer's FCC RN 0019191253

Persons willfully making false statements on this form can be punished by fine or forfeiture under the Communications Act, 47 U.S.C. Secs. 502, 503(b), or fine or imprisonment under Title 18 of the United States Code, 18 U.S.C. Sec. 1001.

FCC NOTICE FOR INDIVIDUALS REQUIRED BY THE PRIVACY ACT AND THE PAPERWORK REDUCTION ACT

Part 3 of the Commission's Rules authorize the FCC to request the information on this form. The purpose of the information is to determine your eligibility for certification as a health care provider. The information will be used by the Universal Service Administrative Company and/or the staff of the Federal Communications Commission, to evaluate this form, to provide information for enforcement and rulemaking proceedings and to maintain a current inventory of applicants, health care providers, billed entities, and service providers. No authorization can be granted unless all information requested is provided. Failure to provide all requested information will delay the processing of the application or result in the application being returned without action. Information requested by this form will be available for public inspection. Your response is required to obtain the requested authorization.

The public reporting for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the required data, and completing and reviewing the collection of information. If you have any comments on this burden estimate, or how we can improve the collection and reduce the burden it causes you, please write to the Federal Communications Commission, AMD-PER, Paperwork Reduction Act Project (3060-0804), Washington, DC 20554. We will also accept your comments regarding the Paperwork Reduction Act aspects of this collection via the Internet if you send them to pra@fcc.gov. PLEASE DO NOT SEND YOUR RESPONSE TO THIS ADDRESS.

Remember - You are not required to respond to a collection of information sponsored by the Federal government, and the government may not conduct or sponsor this collection, unless it displays a currently valid OMB control number or if we fail to provide you with this notice. This collection has been assigned an OMB control number of 3060-0804.

THE FOREGOING NOTICE IS REQUIRED BY THE PRIVACY ACT OF 1974, PUBLIC LAW 93-579, DECEMBER 31, 1974, 5 U.S.C. 552a(e)(3) AND THE PAPERWORK REDUCTION ACT OF 1995, PUBLIC LAW 104-13, OCTOBER 1, 1995, 44 U.S.C. SECTION 3507.

Third Party Authorization Upload:
Third Party Authorization Effective Start Date:
Third Party Authorization Effective End Date:

Block 4: Contact Information

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35 Employer		
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